Shoulder MRI & Xray review form

Please complete and return to Dr. McLaughlin with your xrays and/or MRI for evaluation.

Name: _____ Date of birth: _____

Age: ____

Address: _____

City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

Involved hip (circle): Right Left Both

Location of symptoms (circle): Groin Lateral Hip Buttock

Date of injury: _____ and/or Length of symptoms: ___

Night Pain: Yes No

Do you limp: Yes No

What activities cause you to have pain?

Exam(s) you are sending (circle):

X-rays Date of exam: _____

MRI Date of exam: _____

Send to:

Robert E. McLaughlin II, MD

47 Forster Rd

Manchester, MA 01944